STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITTENBERG LUTHERAN VILLAGE	1200 EAST LUTHER DRIVE CROWN POINT, IN46307

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F0000	This visit was for the Investigation of Complaint IN00089783. Complaint IN00089783 substantiated no deficiencies related to the allegations area cited. Unrelated deficiencies cited. Survey dates: May 11 and 12, 2011 Facility number: 000515 Provider number: 155608 AIM number: 100290820 Survey team: Janelyn Kulik, RN, TC Heather Tuttle, RN (May 12, 2011) Census bed type: SNF/NF: 151 Total: 151 Census payor type: Medicare: 22 Medicaid: 85 Other: 45 Total: 151 Sample: 5	F0000	Please accept this Plan of Correction as our allegation of compliance. This Plan of Correction is being submitted for the purpose of complying with regulatory requirements and in no way should be deemed as an admission of any of the allegations contained within the survey findings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 5-17-11 Cathy Emswiller RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview the facility failed to ensure physicians' orders and care plans were followed related to the resident not being allowed access to a knife and one on one supervision being provided for 1 of 1 residents reviewed with behaviors in a sample of 5. (Resident #B, #G, #H, and #J) Findings included: On 5/12/11 at 7:45 a.m. Resident #B was observed sitting at a dining room table with three other residents. CNA #1 was observed standing to the right side of the resident. CNA #1 left Resident #B's side to help other resident's in the dining room. The resident was observed with only a fork but the other three resident's at the table had knives. CNA #1 returned to the left side of Resident #B and cut the ham on his plate. Then CNA #1 laid the knife	F0282	F 2821. The LPN removed the object per the plan of care immediately. There was immediate reinforcement of the job responsibilities with the 1:1 caregiver. The IDT met immediately to modify interventions for this resident. The team determined that a private room off of the Dementia unit may decrease stressors and triggers, and 1:1 care to continue. 2. Any resident on 1:1 supervision has the potential to be affected by the alleged deficient practice. "Supervision and Protection of the Residents with Behaviors that Affect Themselves or Others Policy" was reviewed and revised on 5/21/11 to ensure there was a clear set of criteria for determining the necessity of 1:1 supervision and appropriate interventions. One other resident was one 1:1 Supervision at this time. Care plan, interventions, Resident Care Sheet were reviewed by IDT and found to be	06/03/2011

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	on the table by Resident #B's plate. CNA #1 then left the side of the table leaving the resident unattended. LPN #1 was then observed removing the knife that was place on the table by the resident's plate from the table. On 5/12/11 at 7:55 a.m. Resident #B was observed in the dining with no staff member at his side. Review of a Physician Order Statement (POS) dated 5/10/11, indicated the resident was to have no knives at meal time. Review of a care plan initiated on 4/22/11, indicated a problem of "I am new to this environment and will require an adjustment period." The interventions included, but were not limited to, one on one supervision. A nursing note dated 4/23/11 at 5:40 p.m., indicated while in the DR (dining room) for dinner res (sic) threw coffee at wife (Resident #G). Res (sic) became increasingly agitated et (and) aggressive waving butter knife around in a hostile manner. Res. (sic) then approached Resident #H and began tapping her on Left upper extremity with butter knife in aggressive manner. Resident #B's attention was diverted and the nurse was		appropriate and being followed. 3. Revised the policy "Supervision and Protection of Residents with Behaviors that can Affect Themselves or Others " on 5/21/2011. LPN's, RN's, QMA's, CNA's will be in-serviced on "Supervision and Protections of the Residents with Behaviors that Affect Themselves and Others" policy on 6-1-11 and 6-3-11.4. 1:1 supervision audit was revised and the audit will be conducted randomly across all shifts, daily for one week, then weekly for three weeks then monthly x 12 months. The Quality Assurance Committee to monitor for trends and compliance. Compliance date June 3rd 2011	

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	able to stand between them. Then Resident #B approached Resident #J and began hitting her in the back with fist while holding butter knife. The nurse stepped in to remove butter knife from resident and resident lacerated the nurses abdomen then hit the nurse on the left side of neck with coffee cup that he was holding in other hand. The nurse was able to get resident seated in chair and the resident began to relax. Resident sat for a few minutes then left the dining room with one on one aide. Physician was notified and a new order was received to send the resident to the emergency room. A nursing note dated 5/10/11 at 3:45 p.m.,indicated the resident was readmitted to the facility. One on one supervision was initiated due to history of behaviors. Interview with CNA #2 on 5/12/11 at 7:50 a.m., indicated that CNAs have care sheets that inform the CNAs of the care needs of the resident. CNA #2 indicated she did not have her care sheet. Interview with CNA #3 on 5/12/11 at 7:52. a.m., indicated she was doing one on ones today and she did not have a care sheet. Interview with CNA #1 on 5/12/11 at 7:55			

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	a.m., indicated she was a float and did not know where she would be working. She did not have her care sheet. Interview with CNA #1 on 5/12/11 at 7:58 a.m., indicated she now had her care sheet. The care sheet indicated Resident #B was to have "no knives". Interview with the Clinical Care Coordinator on 5/12/11 at 8:45 a.m., indicated she was aware of the knife being placed by Resident #B and a new system was being put into place so that would not happen again. Interview with CNA #1 on 5/12/11 at 8:55 a.m., indicated she was doing one on ones with Resident #B. She further indicated she was aware the resident was not to have a knife. She had cut his ham and put the knife down. It was her fault she was aware he was not to have a knife. Interview with the Clinical Care Coordinator and Health Care Service Director on 5/12/11 at 1:05 p.m., indicated one on one staff is supposed to be with the resident at all times. 3.1-35(g)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview the facility failed to ensure interventions were in place and supervision was provided for 1 of 1 residents reviewed with behaviors in a sample of 5 related to one on one supervision, no receiving a knife during mealtimes and providing interventions and supervision for aggressive behavior.. (Resident #B, #G, #K, and #L) Findings included: On 5/12/11 at 7:45 a.m. Resident #B was observed sitting at a dining room table with three other residents. CNA #1 was observed standing to the right side of the resident. CNA #1 left Resident #B's side to help other resident's in the dining room. The resident was observed with only a fork but the other three resident's at the table had knives. CNA #1 returned to the left side of Resident #B and cut the ham on his plate. Then CNA #1 laid the knife on the table by Resident #B's plate. CNA #1 then left the side of the table leaving the resident unattended. LPN #1 was then observed removing the knife that was place on the table by the resident's plate from the table.	F0323	F 323 The LPN removed the object per the plan of care immediately. There was immediate reinforcement of the job responsibilities with the 1:1 caregiver. The IDT met immediately to modify interventions for this resident. The team determined that a private room off of the Dementia unit may decrease stressors and triggers, and 1:1 care to continue. The IDT reviewed the "Supervision and Protection of Residents with Behaviors that can affect Themselves and Others" policy. The 1:1 criteria was revised to ensure that the criteria is resident specific. All nursing staff will be in-serviced on June 1st and 3rd, 2011 on the responsibilities of the 1:1 position and on the "Supervision and Protection of Residents with Behaviors that can affect Themselves and Others" policy.This training will include a clear set of responsibilities and expectations. 1:1 Supervision and Resident Care sheet audit will be conducted randomly on all shifts, daily for one week, then weekly times three weeks, then monthly x 12 months. The Quality Assurance Committee will review	06/03/2011

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	On 5/12/11 at 7:55 a.m. Resident #B was observed in the dining with no staff member at his side. Review of a Physician Order Statement (POS) dated 5/10/11, indicated the resident was to have no knives at meal time. Review of a care plan initiated on 4/22/11, indicated a problem of "I am new to this environment and will require an adjustment period." The interventions included, but were not limited to, one on one supervision. A nursing note dated 4/9/11 at 6:10 a.m., indicated While Resident #K was walking to the nurses station, the nurse heard her yell "Let me go, let me go". Resident #K was not able to move. Resident #B was grabbing Resident's #K's right arm, then pushed her. Resident #B was not easily redirected. At 6:20 a.m. Resident #B was in the television room trying to move Resident #L in broda chair (reclining chair) out of room and touching her in her face. Resident #L was not happy with touching. The nurse and CNA tried to intervene without success. Resident #B was trying to move the chair aggressively and while the CNA was trying to redirect, the resident tried to hit at him and became		to determine compliance. Compliance date June 3rd 2011	

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	very aggressive. The Resident became unsteady so the CNA tried to lower him to the sofa. The resident was still trying to hit and bite the CNA. At 6:50 a.m. the resident was calm at this time, ambulating in hall with no behaviors. The resident had been up all night. At 7:30 a.m. The resident had been placed on one on one supervision as a safety precaution. The Director of Nursing and Social Service was notified. Social Service recommended one on one supervision until the IDT (Interdisciplinary Team) could review. The physician and family were notified. At 8:00 a.m. a message was left for the physician to call facility regarding refusing meds and behaviors. At 10:55 a.m. The resident was alert and calm at this time. He was on one on one supervision at this time. The physician was aware and new orders were received for CBC (complete blood count), BMP (Blood test), UA (urinalysis), C & S (Culture and Sensitivity), and chest x-ray. The seroquel 150 mg (milligrams) twice a day was to be discontinued and Risperdal 1 mg twice a day was to be started. The resident was to have one on one supervision. At 6:55 p.m. "Resident noted to have increased agitation since 6:05 p.m. The resident had been attempting to drag his spouse (Resident #G) with her walker along with him down the hall. Resident #B was noted to hold			

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	on to walker and try to pull her along. Resident's spouse (Resident #G) was separated from this resident to calm situation. Resident #G began to walk again down hall at about 6:20 p.m. Resident #B was noted to be walking down hall next to his spouse. Resident was noted to be pulling on her front of shirt and on her walker. When 1:1 staff attempted to intervene, resident began to become more aggressive. CNA came to assist 1:1 staff member. Resident #B began to strike 1:1 staff on shoulder with closed fist repetitively. 1:1 staff backed away from situation. Resident #B continued down hall. This nurse brought resident 's spouse (Resident #G) back into office to calm down situation. Supervisor and family notified. Waiting arrival of daughter at present time. Resident's spouse (Resident #G) remains in office at present time. Resident #B noted to be walking down hall. Resident #B attempted to enter another resident's room at 6:50 p.m. CNA attempted to re-direct resident and close door, and resident began to hit CNA with closed fist. CNA backed away from situation. Resident then began to continue down hall. CNA then informed this nurse of above information. Resident walking down hall at present time 1:1 attempting to redirect other residents away from situation. Resident's spouse (Resident #G) in office			

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at present time." At 7:10 a.m. "Resident's spouse (Resident #G) left nurses station to go back to room. Resident #B pulled walker steadily while she was ambulating toward 500 hall dining room. Resident then began to pull his spouses (Resident #G's) walker to control where she was going. This nurse then intervened and brought resident's spouse (Resident #G) back into nurse's station to maintain safety. Resident has been ambulating down hallway. Resident's daughter entered facility to help calm situation down. Will continue to monitor."

A nursing note dated 4/10/11 at 8:30 p.m., indicated Resident #B "ambulating and went into another res (sic) room. tried to enter bathroom when res (resident) was going to bathroom. Nurse stood in front of bathroom door so res (sic) was not (sic) enter bathroom. Also grabbed at another res (sic) lying in bed and pulled off nonskid sock. Res (sic) was also hitting his own arm against wall and cautioned not to do that because he might injure his arm, He said, "I don't give a Sh--." Also was tying to grab at female nurses face and had a grin on his face as he was tying to do it. As wife was approaching "(sic)I asked wife to call to him and she did, at which point res (sic) exited room, res (sic) also entered another res (sic) room but stood in room for only a few minutes and

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	walked out going back to bench." At 9:00 p.m. the resident's behaviors continued to increase. Resident entered another resident's room upon entering room supervisor offered resident a drink in a cup. Resident #B knocked the cup out of supervisors had. Supervisor and one on one stayed with resident. Physician was notified and a new order was received to sent out to emergency room. A nursing note dated 4/22/11 at 4:05 p.m., indicated the resident returned to the facility. At 11:00 p.m. resident with aggressive behaviors towards one on one staff. A nursing note dated 4/23/11 at 5:40 p.m., indicated while in the DR (dining room) for dinner res (sic) threw coffee at wife (Resident #G). Res (sic) became increasingly agitated et (and) aggressive waving butter knife around in a hostile manner. Res. (sic) then approached Resident #H and began tapping her on Left upper extremity with butter knife in aggressive manner. Resident #B's attention was diverted and the nurse was able to stand between them. Then Resident #B approached Resident #J and began hitting her in the back with fist while holding butter knife. The nurse stepped in to remove butter knife from resident and resident lacerated the nurses			

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	abdomen then hit the nurse on the left side of neck with coffee cup that he was holding in other hand. The nurse was able to get resident seated in chair and the resident began to relax. Resident sat for a few minutes then left the dining room with one on one aide. Physician was notified and a new order was received to send the resident to the emergency room. A nursing note dated 5/10/11 at 3:45 p.m.,indicated the resident was readmitted to the facility. One on one supervision was initiated due to history of behaviors. A social service noted dated 4/11/11, indicated on 4/9/11 resident had grabbed another resident's arm, then had touched another resident's face; reviewed video. No contact observed between resident grabbing another, unable to visualize resident touching another's face, did observe him pushing a broda chair from hobby room to dining room with no aggression noted. Spoke with nurse supervisor, resident had not been taking his medication for two days, one on one supervision implemented to ensure safety related to erratic behaviors. Reviewed chart on this date, resident with multiple behaviors of hitting at staff, attempting to bite staff. Psych (sic) NP (Nurse Practitioner) did call in and changed			

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	seroquel to Risperdal liquid. Nurse did note resident with behaviors of pulling spouse (Resident #G) shirt and walked, no harm done to any other resident. Behaviors escalated evening of 4/10 with physical aggression towards staff and resident sent to hospital for evaluation on 4/10. Will initiate one on one supervision upon return to observe for behaviors. Interview with the Clinical Care Coordinator on 5/12/11 at 8:45 a.m., indicated she was aware of the knife being placed by Resident #B and a new system was being put into place so that would not happen again. Interview with CNA #1 on 5/12/11 at 8:55 a.m., indicated she was doing one on ones with Resident #B. She further indicated she was aware the resident was not to have a knife. She had cut his ham and put the knife down. It was her fault she was aware he was not to have a knife. Interview with the Clinical Care Coordinator and Health Care Service Director on 5/12/11 at 1:05 p.m., indicated one on one staff is supposed to be with the resident at all times. Interview with the Health Care Service Director, Clinical Care Coordinator, and Social Service Director on 5/12/11 at 3:00			

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	p.m., indicated on 4/9/11 Resident #B was separated from the Resident #K and put in the television room where he was kept in eye sight of staff prior to him attempting to move Resident #K's broda chair. This information was support by facilities internal investigations forms. It was further indicated that prior to the resident throwing the coffee the one to one staff member was sitting next to the resident but the incident happened so fast it could not be prevented. There was no further information provided as to intervention put into place in regards to the Resident #B pulling on Resident's #G other than removing Resident #G and putting her in the nursing office and there were no other interventions offered in regards to the resident entering other resident's rooms other than redirecting other residents from the situation. 3.1-45(a)(2)			